STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495174	A. BUILDING _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	2978 CENTREVILLE ROAD HERNDON, VA 20171

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare / Medicaid abbreviated standard survey was conducted 11/14/23 through 11/15/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey (VA00059943-substantiated without deficiency; VA00057410-substantiated with deficiency; VA00058287-unsubstantiated). The census in this 166 certified bed facility was 156 at the time of the survey. The survey sample consisted of 4 resident reviews.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		12/26/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/11/2023

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F 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation review, the facility staff failed to ensure the Resident's right to privacy for 1 Resident (Resident #3), in a survey sample of 4 Residents. The findings included: For Resident #3, the facility staff failed to ensure Resident #4, who was a Resident with dementia and wandering behaviors, did not wander into Resident #3's room at will. On 11/14/23 at 1:00 PM Resident #4 was observed in the hall self-propelling wheelchair down hall. She was observed to stop and stay in the doorway and look in the rooms. On 11/14/23 at 1:20 PM an interview was conducted with CNA B (certified nursing assistant-B) who stated they try to keep Residents that wander, out of other Residents rooms however it is not always possible. CNA B stated that Resident #4 has had to be redirected "on many occasions" out of Resident #3's room.	F 583	F583 1. Resident #4 was assigned 1:1 supervision to prevent wandering into others□ rooms. A mesh stop sign was installed to Resident #3□s door frame. 2. Any resident is at risk of having their privacy compromised if a resident wanders into their room without their permission. 3. All staff educated on resident right to privacy. 4. Administrator or designee will audit residents who are at risk of wandering to ensure they are not wandering into other residents□ rooms, daily for 5 days, weekly for 4 weeks, and monthly times two months. Results will be reviewed with the QAA committee and adjustments will be made based on the results. 5. AOC: 12/26/2023	

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F 583	Continued From page 2 CNA B stated that Resident #4 is easily redirected. On 11/15/23 at approximately 10:30 AM an interview was conducted with Resident #3 who was asked about issues with other Residents. Resident #3 stated "That a lady wanders in his room from next door. She comes in, but she doesn't knock it makes me mad if I'm using my urinal or if I'm washing up. That's why I keep my door closed all the time." On 11/15/23 a review of the clinical record revealed that Resident #3 has care planned to keep his door closed to deter Resident #4 from entering his room. On 11/15/23 at approximately 11:00 AM an interview was conducted with the Administrator who stated she was aware that Resident #4 had a wander guard as a result of the assessment in August. When asked if it was her expectation that the information on wandering behaviors and placement of a wander guard be in the care plan she stated that it was her expectation. When asked if she expected there to be interventions to protect the privacy of other Residents and she stated that it was. During the end of day meeting on 11/15/23, the Administrator was made aware of the concerns and no further information was provided.	F 583		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		12/26/23

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F 657	Continued From page 3 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation review, the facility staff failed to ensure care plans were reviewed and revised to accurately reflect changes in care for 1 Resident (Resident #4) in a survey sample of 4 Residents. The findings included: For Resident #4 the facility staff failed to add the wandering risk assessment results, the addition of the wander guard, and interventions for wandering to the comprehensive care plan.	F 657	F657 1. Facility reviewed and updated care plan for Resident #4 to include wandering care plan with wandering device on 12/7/2023. 2. Residents identified at risk for wandering were reviewed to ensure care plans reflect their wandering, or use of a wander-guard. Corrections were made as necessary. 3. The Interdisciplinary Team will be educated on timely review and revision of the care plan.	

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F 657	Continued From page 4 On 11/14/23 at 1:00 PM Resident #4 was observed self-propelling the wheelchair down the hallway. She was observed to stop and stay in the doorway and look in the rooms. On 11/14/23 at 1:20 PM an interview was conducted with CNA B (certified nursing assistant-B) who stated they try to keep Residents that wander, out of other Residents rooms however it is not always possible. CNA B stated that Resident #4 has had to be redirected "on many occasions" out of Resident #3's room. CNA B stated that Resident #4 is easily redirected. On 11/15/23 at approximately 10:30 AM an interview was conducted with Resident #3 who stated he has no issues with the facility. When asked about issues with other Residents he stated "That lady wanders in here from next door. She comes in, but she doesn't knock it makes me mad if I'm using my urinal or if I'm washing up." Resident #3's room was next door to Resident #4, and Resident #4 has a dementia diagnosis with wandering behaviors. On 11/15/23 a review of the clinical record revealed that Resident #3 had care planned to keep his door closed to deter Resident #4 from entering his room. A review of the clinical record revealed a "wandering risk assessment" was completed on 8/14/23. Resident #4 was found to be at risk for wandering and had a wander guard placed on her at that time. A review of the care plan for Resident #4 revealed that her care plan did not	F 657	4. Administrator or designee will audit new admissions for wandering risk weekly for four weeks and monthly times two months. Care plans will be updated based on risk. Results will be reviewed with the QAA committee and adjustments will be made based on results. 5. AOC: 12/26/2023	

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F 657	Continued From page 5 address elopement risk or the wandering assessment nor does it have any care planned interventions for wandering. On 11/15/23 at approximately 11:00 AM an interview was conducted with the Administrator who stated she was aware that Resident #4 had a wander guard as a result of the assessment in August. When asked if it was her expectation that the information on wandering behaviors and placement of a wander guard be in the care plan she stated that it was her expectation. When asked if she expected there to be interventions to protect the privacy of other Residents and she stated that it was. During the end of day meeting the Administrator was made aware of the concerns and no further information as provided	F 657		